BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

CLARENCE E. RODRIQUEZ, M.D.

Holder of License No. **14409**
For the Practice of Allopathic Medicine
In the State of Arizona.

Board Case No. MD-02-0571A

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

(Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on December 11, 2003. Clarence E. Rodriquez, M.D., ("Respondent") appeared before the Board without legal counsel for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). After due consideration of the facts and law applicable to this matter, the Board voted to issue the following findings of fact, conclusions of law and order.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 14409 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-02-0571A after receiving notification of a malpractice settlement involving Respondent's care and treatment of a 67 year-old female patient ("MD").

4. On April 11, 1999 MD was involved in a motor vehicle accident and was admitted to Maricopa Medical Center ("Medical Center"). MD was placed on a ventilator. MD was unable to be weaned from the respirator and required a tracheostomy on April 26, 1999. On April 30, 1999 MD was transferred to Respondent's care at the Apache

Junction Care Center ("Care Center"). At the time of transfer MD was reported to have been doing quite well and was not on antibiotics or pressor agents and was not in critical condition.

5. Respondent was about to go on vacation when MD arrived at Care Center. Respondent called in a few orders for MD the first two or three days after her transfer, but he did not physically see her. On May 1, May 3 and May 4 Respondent called in orders for ventilator settings, a chest x-ray, an EKG (which was to be faxed to him), sputum culture, discontinuance of OxyContin for pain, a nicotine patch, an air mattress and wrist restraints if needed. A colleague ("Physician #2") covered for Respondent during Respondent's vacation. MD was not seen by a physician during her first 10 days at Care Center.

6. On May 8 Respondent ordered Tylenol suppositories for MD for fever if needed. On May 9 he ordered a portable chest x-ray and changed the antibiotic to Cipro per tube. Respondent also ordered lab work and discontinued Levaquin (as ordered by Physician #2). On May 10 Respondent noted MD to be in quite critical condition and ordered her transferred to Valley Lutheran Hospital where she expired the next day.

7. Respondent testified that his understanding was that MD was transferred to Care Center for end of life care and that there were advanced directives that MD not be moved back to the hospital and not be given any more antibiotics. Respondent was asked what his normal practice was for seeing patients transferred to his care at a nursing home. Respondent stated that he normally first sees such patients within three to five days, but since he was going on vacation, he had someone covering for him.

8. Respondent was asked what kind of arrangement he normally makes with the physician who will be covering for him. Respondent stated that he calls his answering service, lets them know he will be gone and tells them which physician will be

covering for him. Essentially, if the nursing home tries to contact Respondent the answering service informs the nursing home which physician is covering for him. Respondent stated that he lets the covering physician know he is leaving town and will either call the physician or send a fax with a list of his patients that are in the hospital. Respondent stated that he does not inform the covering physician of those patients that are in the nursing home, just the hospital.

9. Respondent was asked if the practice of not informing the covering physician that Respondent had patients in the nursing home could lead to those patients not being seen because, unless the nursing home calls with an issue, the covering physician would not even know about these patients. Respondent stated that usually the nursing home calls the physician if they need anything for the patient. Respondent was asked how often a stable patient in a nursing home would actually be seen. Respondent stated that he would see such patients once a month so it was not unusual for a stable patient to not be seen for a two-week period.

10. Respondent was asked about his ordering cultures on May 4 when he was informed that MD's temperature had spiked because it appeared that after MD was diagnosed and assessed no treatment was given. Respondent stated that he was not sure if he put MD on antibiotics because her son did not want her on antibiotics. Respondent's attention was directed to the advanced directive that addressed pain medication, hydration, nutrition, blood transfusions, cardiopulmonary resuscitation and hospitalization, but not antibiotics. Respondent said he was not sure why antibiotics were not on the advanced directive, but that is what sticks in his mind, that she was not to receive antibiotics. Respondent remembering MD's family giving a hard time about antibiotics, however he noted that he never personally spoke with the family and received his information from the nurses.

11. Respondent stated that his first thought in regard to MD was that she was transferred to Care Center to be allowed to pass away because why else would a patient on a ventilator be transferred from ICU to a nursing home with advanced directives not to resuscitate?

12. The transfer summary dictated by the Medical Center physician stated that MD was being transferred to a skilled nursing facility for aggressive pulmonary exercise to further assist her in weaning from the ventilator as she was removed from her initial trauma and the associated injuries. It would be reasonable for a pulmonary specialist who is seeing a patient who is transferred to his/her care because of significant pulmonary problems to conduct a personal evaluation of the patient within a reasonable period of time.

13. Respondent stated that he chose not to see MD before he went on vacation because he thought she transferred to be allowed to pass away. Respondent stated that when he returned from vacation he had a message from the medical director of Care Center telling him to go see MD. Respondent said he immediately called Care Center and when he was told of her condition he immediately transferred her to the hospital. Respondent was asked why, if he believes MD was at Care Center in order to die, he transferred her to the hospital. Respondent said he did so because the family had changed its mind about MD's treatment. Respondent stated that he was not sure if the family's change of instruction was documented. Respondent stated that when he met with the family at the hospital and went over all the problems MD had they indicated they did not want further care.

14. The standard of care required Respondent to follow-up on and evaluate nursing care center transfer patients, particularly complex patients.

15. Respondent fell below the standard of care because he failed to follow-up on and evaluate a complex nursing care transfer patient.

16. MD was harmed because Respondent's failure to follow-up and evaluate her led to the development of an infection that was not recognized and ultimately led to MD's death.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(26[1])(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the patient or the public.")

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED that Respondent is issued a Letter of Reprimand for failure to appropriately follow-up and treat a ventilator dependent nursing care center patient.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. Pursuant to A.R.S. § 41-1092.09, as amended, the petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after

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[1] Formerly A.R.S. § 32-1401(24). Renumbered effective September 18, 2003.

service of this Order and pursuant to A.A.C. R4-16-102, it must set forth legally sufficient reasons for granting a rehearing or review. Service of this order is effective five (5) days after date of mailing. If a motion for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 17th day of February, 2004.

THE ARIZONA MEDICAL BOARD

By Amanda Field
for BARRY A. CASSIDY, Ph.D., PA-C
Executive Director

ORIGINAL of the foregoing filed this 17th day of February, 2004 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Certified Mail this 17th day of February, 2004, to:

Clarence E. Rodriquez, M.D.
Address of Record

Lisa McGraw